COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.virginia.gov

MEMORANDUM

TO: CSB Executive Directors
Facility Directors

FROM: James S. Reinhard, M.D.

DATE: July 24, 2007

SUBJECT: Guidance to CSBs and State Hospitals Regarding Involuntary Outpatient Commitment and Implementation of IOC Orders

As you know, CSBs/BHAs have reported that involuntary outpatient commitment is used very differently in different parts of the Commonwealth. In some areas, for instance, involuntary outpatient commitment is never used, while in other areas it appears to be used quite regularly. Its use appears to be increasing over the past few months in some areas, but overall, involuntary outpatient commitment is a relatively infrequent disposition. Preliminary analysis of the data from the special justice survey during May 2007 indicates that it was used in approximately 6% of reported cases.

The prevailing interest in involuntary outpatient commitment has prompted several inquiries from CSBs/BHAs and other providers about Virginia's current outpatient commitment law and its application in the Commonwealth. In response to these questions, I am disseminating the attached information, which is offered as guidance to CSBs/BHAs and state hospitals regarding the use of involuntary outpatient commitment.

Involuntary outpatient commitment is a complex procedure that requires a significant amount of collaborative planning, good communication, and effective coordination among several parties. Even with these elements in place, we recognize that effective use of involuntary outpatient commitment also requires an adequate array of services tailored to meet the needs of the individual, and that these services are not uniformly available and accessible throughout the Commonwealth. The attached guidance should be of assistance to you as you consider the involuntary outpatient commitment option for the people you serve.

We will continue to work with CSBs/BHAs and others to better understand the use of involuntary outpatient commitment statewide, and will offer additional guidance in the future as issues arise.

Attachment

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.virginia.gov

July 24, 2007

Guidance to CSBs and State Hospitals
Involuntary Outpatient Commitment (IOC) and Implementation of IOC Orders

1. General Planning for Involuntary Outpatient Commitment: Virginia's involuntary outpatient commitment law (§37.2-817C of the *Code of Virginia*) does not explicitly describe all the steps that must be followed or actions that must be taken to effectively implement an involuntary outpatient commitment order. Therefore, it is important that every person and agency that may be involved in implementing an involuntary outpatient commitment (IOC) order share a common understanding of what the relevant law means and of how the parties working together will put the law into practice. These parties include at a minimum the CSBs/BHAs, judges and special justices, court clerks, law enforcement agencies, independent examiners, and any other providers who might be involved in providing or monitoring services pursuant to an IOC order.

Involuntary outpatient commitment requires advance planning to address both general requirements and case-specific communication and coordination. With this in mind, CSBs/BHAs should convene the above stakeholders to review the involuntary outpatient commitment and related statutes, achieve a common understanding of explicit and implicit requirements of the law, and develop a mechanism to implement those requirements.

If involuntary outpatient commitment orders will be used in your area, all stakeholders should be very clear about their specific responsibilities in developing, implementing and monitoring any order. Stakeholders should also keep in mind that individual IOC orders will differ from each other in terms of services and other requirements and will therefore require individualized variations from the general practice. Different potential scenarios should be reviewed to ensure that procedures adopted locally (or regionally) are both consistent with statutory requirements and responsive to potential individual needs.

2. Developing the treatment plan for involuntary outpatient commitment: To issue an involuntary outpatient commitment order under §37.2-817.C, the presiding judge or special justice must make several determinations regarding the individual and the proposed outpatient treatment. The statute refers specifically to a *"treatment plan"*, and requires the CSB/BHA *"that serves the city or county where the person resides"* to recommend *"a specific course of treatment and programs"* for any person subject to an IOC order. This language means that a treatment plan should be developed by the appropriate CSB/BHA and incorporated into the IOC order itself (e.g., as an attachment or supplement).

There are numerous practical issues that must be resolved to accomplish this. For instance, the treatment plan must be prepared in advance of the issuance of the IOC order. For the plan to be developed in advance of the IOC order, there must be communication and coordination between the CSB *"that serves the city or county where the person resides"*, other providers (possibly another CSB), the person and his or her attorney, and possibly the independent examiner and family. Sufficient time must be given to accomplish the treatment planning in advance of the issuance of the IOC order.

In many cases, it will not be possible to develop a comprehensive treatment plan with extensive assessments, goals and objectives, strategies and interventions, etc. Regardless, the proposed treatment plan should be clear and specific enough to enable the individual, his attorney, his family, if applicable, the judge or special justice, the CSB serving the community where the person resides, and any other providers (CSB or other) to know what services will be provided to the person following the hearing, by whom, and when. The communication and coordination needed to implement the proposed treatment should take place between the individual, the court (including the special justice and the clerk), the CSB serving the person's home, the family and all other involved providers before the issuance of any IOC order.

3. CSB participation in involuntary commitment hearings: Although all persons must be pre-screened by a CSB prior to involuntary commitment, CSB staff is not specifically required by law to attend or otherwise participate in involuntary commitment hearings. Nevertheless, CSB staff should actively participate in commitment hearings in order to most effectively present the preadmission screening report and recommendations for care and treatment and monitor the hearing outcome. Through their participation and active involvement, CSBs ensure that consumers gain access to the least restrictive and most appropriate treatment and supports in a timely fashion, that planned services are well coordinated, and that available services are most effectively utilized.

Absent in-person participation, CSBs should utilize telephone or teleconferencing technology or arrange for other representatives (e.g., from another CSB) to attend these hearings on their behalf. If a CSB does not participate in involuntary commitment hearings involving its own consumers, whether occasionally or routinely, then a clear procedure should be in place for communicating and coordinating all relevant information from the presiding courts to the appropriate CSB staff or other providers regarding the outcomes of the hearing, treatment ordered, any required monitoring, and any other pertinent information.

4. Differences of opinion between independent examiners and CSB preadmission screeners: During the commitment hearing, evidence is considered from several sources, and may not always be consistent. Witnesses will not necessarily share the same perspectives on the evidence, nor have the same outcomes in mind. Additional information, clarification or perspectives may also be developed during the course of the testimony.

At times a CSB preadmission screener's evaluation of an individual or his recommendation for treatment and disposition may differ from that of the independent examiner. When this occurs, neither the CSB preadmission screener nor the independent examiner is obliged to reconcile their different findings and recommendations, and the hearing may proceed to its conclusion without a consensus between these two clinicians.

However, the preadmission screener and independent examiner may want to discuss between themselves the reasons for the discrepancies and be prepared to discuss them at the hearing. Information in the possession of one may inform the opinion of the other. For example, the preadmission screener may have additional information that is not readily apparent from the preadmission screening form, or the independent examiner may have the benefit of more recent clinical information developed during the period of temporary detention, or access to additional clinical records that might inform the preadmission screener's recommendations regarding treatment.

Finally, § 37.2-817.C. requires the judge or special justice to observe the person, obtain "*the necessary positive certification*" and consider other relevant evidence that may have been offered. Many judges and special justices interpret this provision to require that the independent examiner certify that the person meets the commitment criteria before the court may enter an inpatient or outpatient commitment order, regardless of the other evidence presented at the hearing.

5. Confidentiality provisions: Under § 321-127.1:03(D)(2), a health care provider may disclose information pursuant to a court order. Thus, a court may order the monitoring CSB or other designated provider to make reports to the court regarding a person's compliance or non-compliance with the IOC order. The court may order that such reports be made on a periodic basis or only when the person is non-compliant.

In order for the monitoring CSB or other designated provider to make reports to the court regarding a person's compliance, information will need to be obtained from providers delivering services to the person under the IOC order. Both the HIPAA Privacy Rule and the Virginia Patient Health Records Privacy Act permit providers to make disclosures of health information to other providers for treatment purposes without patient authorization (see 45 C.F.R. 164.506; Va. Code § 32.1-127.1-03(D)(7)). "Treatment" is defined by the HIPAA Privacy Rule to mean the provision, coordination or management of health care. (see 45 C.F.R. 164.501). Because a report by a provider to the monitoring CSB or provider regarding a person's compliance with treatment is for the purpose of coordinating and managing the person's health care, such a report can be made without patient authorization. Although not necessary to permit such disclosures, the court may also order providers delivering services to the person to inform the monitoring CSB or other designated provider regarding the person's compliance.

6. Monitoring and reporting adherence with IOC orders: Section 37.2-817.C states that *"the community services board, behavioral health authority, or designated provider shall monitor the person's compliance with the treatment ordered by the court under this section"*. Specific responsibilities for monitoring and reporting an individual's adherence to court-ordered treatment should be worked out during the hearing and prior to the issuance of an IOC order so that these requirements can become part of the order itself. Monitoring requirements and responsibilities should be situation specific and might take different forms depending on the nature of the treatment and other circumstances. For instance, monitoring could require noting appointments kept and missed, making a home visit every two weeks, talking to the individual's family each week, obtaining progress reports from another provider, or something else. Monitoring may also be the responsibility of a non-CSB provider. The agreed-upon monitoring process should also include all reporting requirements (e.g., from provider(s) to the court and to the CSB) and should reflect who will report what, to whom, how often, and under what circumstances.

7. Non-compliance with IOC orders: There may be many reasons for a person's non-compliance with an involuntary outpatient treatment order, some of which may be justifiable or inconsequential. As a practical matter, "substantive or material" non-compliance depends on two factors - the specific nature of the non-compliance and the individual's clinical condition and circumstances at the time. In other words, the seriousness of non-adherence with treatment can be mitigated by the individual's own well-being and circumstances.

The court, involved providers and the person subject to the IOC order (and any other persons, such as family members) should discuss and agree upon what circumstances will constitute substantive or material non-compliance, i.e., circumstances sufficient to trigger intervention, reporting or another response. If a treatment provider or the entity responsible for monitoring the IOC order is to determine substantive or material non-compliance, then these agreements should be well understood by all parties and incorporated into the IOC order at the time it is issued.

8. Enforcement of IOC orders: Virginia law provides no explicit mechanism for enforcing compliance with IOC orders, but courts and providers may employ various persuasive strategies to enhance a person's participation in and adherence to treatment ordered by a court under §37.2-817.C.

Under § 37.2-803, the special justice has all the powers and jurisdiction conferred upon a judge for the purpose of performing the required duties of a judge under Title 37.2. This has been interpreted by many judges to include the power to issue a Rule to Show Cause directed to the person if he fails to comply with an involuntary outpatient commitment order, a *capias* (i.e., a legal order) directing the sheriff to bring the person before him if the person fails to appear, and the power to find the person in contempt of court for failure to follow the order. Whether and under what circumstances the special justice will consider using these powers should be discussed prior to a specific case arising, and how these powers will be implemented, such as where and when the person must appear, and where the person may be held pending the hearing, must be resolved with the court clerks, law enforcement and participating facilities.

In lieu of a *capias*, the court could also consider asking the magistrate to issue an emergency custody order so that the person may be brought to a convenient location for the CSB/BHA to assess whether continued detention and another commitment hearing may be necessary. The previous finding by the court that the person meets commitment criteria could be used as a basis for the probable cause to support issuance of an ECO. Whether that finding is sufficient, however, would depend upon the length of time that has passed since the commitment hearing, and whether and to what extent the person participated in and may have benefited from the outpatient treatment ordered. Such determinations would need to be made on a case-by-case basis.

In general, if IOC is likely to be used in your area, it is important for all parties to understand clearly what strategies the presiding court(s) could use to encourage adherence to the treatment plan, as well as any strategies that could be used by CSBs or other providers. Similarly, before issuing an individual IOC order, it should be clearly understood by the court, involved providers and the person subject to the IOC order (and any other relevant persons, such as family members) exactly what measures will be taken to secure compliance with the IOC order and under what circumstances.

It should also be noted that non-compliance with an IOC order issued under §37.2-817.C can be used as evidence in a subsequent commitment hearing. However, evidence of non-compliance with an IOC order cannot be the sole basis for an order for involuntary admission to inpatient treatment. If a judge or special justice wishes to revoke an IOC order with the intent of hospitalizing the person on an involuntary basis, then the person must still be given notice, have a commitment hearing and meet the statutory criteria for involuntary hospitalization. A person who is subject to an IOC order may also be subject to an emergency custody or temporary detention order, if conditions are met for issuance of those orders.

Further, it is unlawful to administer anti-psychotic medication to an individual over his objection, even if the individual is subject to an order of involuntary admission (including an IOC order) unless such treatment with medication is authorized under § 37.2-1100 *et seq*.

9. Reporting to the Central Criminal Records Exchange: Any involuntary commitment order issued under § 37.2-817 must be forwarded by the clerk of the court to the Central Criminal Records Exchange (CCRE) pursuant to § 37.2-819. These orders are filed by the clerk with a form provided by the Virginia State Police, which administers the CCRE. Historically, in many court jurisdictions and in many facilities where commitment hearings are held, persons who are not court personnel have managed this transaction (i.e., attaching the State Police reporting form to the court order, batching the orders, and delivering them to the court clerk for forwarding to the CCRE). The Department advises that these functions should be handled by actual court personnel, not by CSB staff or other providers.